

Infection Control Policy

Purpose: To provide a comprehensive infection control system which maximizes protection against communicable diseases for all members, and for the public that they serve.

Scope: This policy applies to all members, career, and volunteer, providing rescue or emergency medical services.

This department recognizes that communicable disease exposure is an occupational health hazard. Communicable disease transmission is possible during any aspect of emergency response, including in-station operations. The health and welfare of each member is a joint concern of the member, the officers, and this EMS service. While each member is ultimately responsible for his or her own health, the department recognizes a responsibility to provide as safe a workplace as possible. The goal of this program is to provide all members with protection from occupationally acquired communicable disease.

It is the policy of this department:

- To provide rescue and emergency medical services to the public without regard to known or suspected diagnoses of communicable disease in any patient.
- To regard all patient contacts as potentially infectious. Standard precautions will be observed at all times and will be expanded to include all body fluids and other potentially infectious material.
- To provide all members with the necessary training, immunizations, and personal protective equipment (PPE) needed for protection from communicable diseases.
- To recognize the need for work restrictions based on infection control concerns.
- To prohibit discrimination of any member for health reasons, including infection and/or seroconversion with HIV/HBV virus.
- To regard all medical information as strictly confidential. No member's health information will be released without the written consent of the member.

[Your City] EMS PROGRAM
EXPOSURE CONTROL PLAN

PURPOSE: To identify those tasks and corresponding job classifications for which it can be reasonably anticipated that an exposure to blood, other body fluids, or other potentially infectious materials may occur, to establish a schedule for implementation of the department's infection control plan, and to identify the procedure for the evaluation of circumstances surrounding exposure incidents.

I. EXPOSURE DETERMINATION

The following tasks are reasonably anticipated to involve exposure to blood, body fluids, or other potentially infectious materials:

Provisions of emergency medical care to injured or ill patients

Rescue of victims from hostile environments, including burning structures or vehicles, water contaminated atmospheres, or oxygen deficient atmospheres

Extrication of persons from vehicles, machinery, or collapsed excavations or structures

Training, as in CPR, First aid, etc.

Recovery and/or removal of bodies from any situation cited above

Response to hazardous materials emergencies involving potentially infectious substances

The following job classifications are reasonably anticipated to involve exposure to blood, body fluids, or other potentially infectious substances in the performance of their duties:

Job classifications with high probability of contact with infectious substances:

All EMS Responders	Vehicle Operators
Rescue Personnel	

Job classifications with low to moderate probability of contact with infectious substances:

Student Interns/Observers	Administrator
Clerical Staff	

II. IMPLEMENTATION

The Infection Control Program is applicable to all members, career, and volunteer, providing rescue or emergency medical services. It is effective immediately. The Infection Control Program consists of a policy statement, identification of roles and responsibilities, Standard Operating Procedures (SOPs), training, and record keeping. SOPs identify specific procedural guidelines for all aspects of response and station environments where disease transmission can be reasonably anticipated, as well as training, administrative aspects of the program, and post-exposure evaluation/investigation. Specific program components are identified as follows:

Infection Control Policy Statement
Exposure Control Plan

SOP #IC 1: Health Maintenance
SOP #IC 2: Infection Control Training
SOP #IC 3: Station Environment
SOP #IC 4: Personal Protective Equipment
SOP #IC 5: Scene Operations
SOP #IC 6: Post-Response (Housekeeping)
SOP #IC 7: Post-Exposure Protocols
SOP #IC 8: Compliance and Quality Monitoring/Program Evaluation

III. EVALUATION OF EXPOSURE INCIDENTS

The procedure for the evaluation/investigation of circumstances surrounding incidents of exposure to blood, other body fluids, or other potentially infectious materials is detailed in SOP #7: Post Exposure protocols. Medical follow-up, documentation, record keeping, and confidentiality requirements are also defined in SOP #IC 7.

SOP # IC 1: Health Maintenance

No member will be assigned to emergency response duties until appropriate medical personnel have performed a physical assessment. At a minimum, this will consist of a health history, vital signs, and lung sounds.

Work restrictions for reasons of infection control may be initiated by the Medical Director or the Designated Officer (Rescue Captain). These may be temporary or permanent. As an example, members with extensive dermatitis or open skin lesions on exposed areas may be restricted from providing patient care or handling and/or decontamination of patient care equipment.

All members will be offered immunization against hepatitis B, influenza, and tetanus. The risks and benefits of immunization will be explained to all members, and informed consent obtained prior to immunization.

Members may refuse immunizations, or may submit proof of previous immunization. Members who refuse immunization will be counseled on the occupational risks of communicable disease, and required to sign a refusal of immunization form. Members who initially refuse immunization may later receive immunization upon request.

All members will be offered initial and yearly screening for tuberculosis exposure.

All members will receive annual health evaluations to include vital signs and respiratory assessment.

Any member returning to work following debilitating injury, illness, or communicable disease (occupational or non-occupational) will be cleared by the Medical Director or designee prior to resuming emergency response duties.

The department Designated Officer (Rescue Captain) and Medical Director will maintain records in accordance with Federal OSHA CFR 29, Part 1910.1030. Member participation in the Infection Control Program will be documented, including:

- Name of member
- Immunization records
- Circumstances of exposure to communicable diseases
- Post-exposure medical evaluation, treatment, and follow-up

Infection control records will become a part of the member's personal health file and will be maintained for duration of employment plus thirty years.

Medical records are strictly confidential. Medical records will be maintained in the office of the Designated Officer, and will not be kept with personnel records. Medical records will not be released without the signed written consent of the member. There will be no exceptions to this policy for Department Administration, Governmental

Administration (with the exception of court orders), or insurance companies.

Records of participation in member assistance programs or critical incident stress debriefing are considered medical records.

Abstracts of medical records without personal identifiers may be made for quality assurance, compliance monitoring, or program evaluation purposes, as long as the identity of individual members cannot be determined from the abstract.

SOP # IC 2: Infection Control Training

All members providing emergency services will be required to complete:

- Initial infection control training at the time of assignment to tasks where occupational exposure may occur.
- Refresher infection control training at least annually thereafter.

All infection control training materials will be appropriate in content and vocabulary to the educational level, literacy, and language of members being trained.

Training will comply with NFPA Standard 1581 and OSHA Regulation 29 CFR Part 1910.1030 and shall include:

- An accessible copy of 29 CFR Part 1910.1030 and an explanation of its contents.
- A general explanation of the epidemiology and symptoms of bloodborne diseases;
- An explanation of the modes of transmission of bloodborne pathogens;
- An explanation of the department exposure control plan and how the employee can obtain a copy.
- An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;
- Information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment.
- An explanation of the basis for selection of personal protective equipment;
- Information on the hepatitis B vaccine, including information on its efficacy, safety, and the benefits of being vaccinated, notification that the vaccine and vaccination will be provided at no charge.
- Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
- Information on the post-exposure evaluation and follow-up that the department is required to provide following an exposure incident.
- An explanation of the signs and labels and/or color-coding required for biohazard materials; information on the proper storage and disposal of biohazard materials.
- Opportunity for interactive questions and answers

Infection control trainers shall be knowledgeable in all of the program elements listed above, particularly as they relate to emergency services provided by this department.

Written records of all training sessions will be maintained for three years after the date on which the training occurs. Training records will include:

- The dates of the training sessions,
- The contents or a summary of the training sessions,
- The names and qualifications of persons conducting the training, and

- The names and job titles of all persons attending the training sessions.

SOP # IC 3: Station Environment

Storage, decontamination, and disposal areas

Areas will be designated for:

1. Equipment decontamination and disinfection (laundry/dirty utility room)
2. Storage of clean patient care equipment and infection control personal protection equipment (EMS locker).
3. Storage of biohazard waste (specially marked waste receptacles).

Under no circumstances will kitchens, bathrooms, or living areas be used for decontamination or storage of patient care equipment or infectious waste.

Decontamination of all contaminated work surfaces will be done with an appropriate disinfectant. This must take place:

1. Immediately or as soon as feasible when surfaces are contaminated
2. At the end of the work shift if the surface may have been contaminated since the last cleaning

SOP # IC 4: Personal Protective Equipment

Specification, purchase, storage, and issue of personal protective equipment (PPE)

Standards for personal protective equipment will be developed by the Rescue Captain, and be updated or modified as needed.

The department is responsible for the supply, repair, replacement, and safe disposal of infection control PPE.

The Rescue Captain will determine proper stock supply levels of PPE both for stations and for response vehicles.

Available PPE (in addition to PPE for rescue and EMS response) will include disposable gloves, rubber gloves for disinfection purposes, facemasks, eye protectors, full-face shields, fluid-impervious gowns, sharps containers, and leak proof disposal bags.

Disposable gloves will be constructed of latex rather than plastic, unless precluded by allergies. While both types provide equal protection, latex is more durable during on-scene operations.

Sharps containers will be closable, puncture resistant, and leak proof. Sharps containers will be color coded, labeled as a biohazard, and immediately accessible.

All EMS responders will be issued a pocket mask with a one-way valve. Replacement pocket masks will be carried on every response vehicle and stocked at the station.

Selection and use of personal protective equipment

Emergency response often is unpredictable and uncontrollable. While blood is the single most important source of HIV and HBV infection in the workplace, in the field it is safest to assume that all body fluids are infectious. For this reason, PPE will be chosen to provide barrier protection against all body fluids.

No standard operating procedure or PPE ensemble can cover all situations. Common sense must be used. When in doubt, select maximal rather than minimal PPE.

Disposable latex gloves will be worn during any patient contact when potential exists for contact with blood, body fluids, non-intact skin, or other infectious material. All members will carry extra pairs of disposable gloves in turnout coats and/or EMS jackets.

Gloves will be replaced as soon as possible when soiled, torn, or punctured. Hands must be washed after glove removal.

Disposable latex gloves will not be reused or washed and disinfected for reuse.

Where possible, gloves should be changed between patients in multiple casualty situations. Hands should be cleaned with disinfectant towellettes that are immediately available.

Structural firefighting gloves, or leather gloves will be worn in situations where sharp or rough edges are likely to be encountered. Latex gloves are to be worn in conjunction with any of the above.

Heavy-duty utility gloves may be used for the handling, cleaning, decontamination, or disinfection of potentially contaminated patient care equipment.

Facial protection will be used in any situation where splash contact with the face is possible. Facial protection may be afforded by using both a facemask and eye protection, or by using a full-face shield. When treating a patient with a suspected or known airborne transmissible disease, a facemask will be used. The first choice is to mask the patient, if this is not feasible, mask the member(s).

Fluid-resistant gowns are designed to protect clothing from splashes. Response gear and EMS jackets also protect clothing from splashes and are preferable in fire, rescue, or vehicle extrication activities. Gowns may interfere with, or present a hazard to, the member in these circumstances. The decision to use barrier protection to protect clothing, and the type of barrier protection used, will be left to the member. EMS jackets and helmets will always be worn for vehicle extrications. Remember leather cannot be cleaned if body fluids are splashed onto leather parts of gear.

Under certain circumstances, head covers and/or shoe covers will be required to protect these areas from potential contamination. Structural firefighting gear (impervious boots, helmets) also may be used for barrier protection. EMS helmets may be used for head covers. If foot covers are needed, they will be stocked in the ambulances.

Summary

- If it is wet, it is infectious - use gloves
- If it could splash onto your face, use eye shields and mask or full face shield.
- If it is airborne, mask the patient or yourself
- If it could splash on your clothes, use a gown, structural firefighting gear, or EMS coat
- If it could splash on your head or feet, use appropriate barrier protection.

PPEPLAN FOR INFECTIOUS EXPOSURE: Task Analysis Chart

NOTE: Department-issue jackets or fire turnouts shall be worn on all medical responses. Protection below is required in addition.

TASK/SITUATION	GLOVES ₁	GOWN ₃	EYEGEAR & MASK ₄
Any light contact with blood or other body fluids. This includes starting IVS, drawing blood.	X		
Heavy bleeding or large amounts of other body fluids, including vomiting, childbirth, urine/fecal contamination, etc.	X	X	Optional ₂
Spraying/splattering body fluids or situations when this can be anticipated	X	X	X
Endotracheal intubation (including nasal); airway suction	X	X	X

1. The use of disposable exam gloves, donned before patient contact, is strongly recommended on every medical response.
2. Optional, at employee's judgment.
3. Examples: arterial bleeding; combative bleeding patients; uncontrolled vomiting; airway care as described in footnote #4
4. To be used when spraying fluid can be expected. Examples: breathing patient; chest compressions in progress; blood, vomit or other fluid in the airway.

SOP # IC 5: Scene Operations

The blood, body fluids, and tissues of all patients are considered potentially infectious, and Standard Precautions/Body Substance Isolation procedures will be used for all patient contact.

The choice of personal protective equipment is specified in SOP # IC 4. Members will be encouraged to use maximal rather than minimal PPE for each situation.

While complete control of the emergency scene is not possible, scene operations as much as possible will attempt to limit splashing, spraying, or aerosolization of body fluids.

The minimum number of members required to complete the task safely will be used for all on-scene operations. When lifting and moving patients, ensure that there are sufficient members to protect the responders and the patient. Members not immediately needed, will remain a safe distance from operations where communicable disease exposure is possible or anticipated.

Hand washing is the most important infection control procedure.

Member will wash hands:

- After removing PPE
- After each patient contact
- After handling potentially infectious materials
- After cleaning or decontaminating equipment
- After using the bathroom
- Before eating
- Before and after handling or preparing food

Hand washing with soap and water will be performed for at least fifteen seconds. If soap and water are not available at the scene, a waterless hand wash (towellettes) may be used, provided that a soap and water wash is performed immediately upon return to quarters or clinic.

Eating, drinking, smoking, handling contact lenses, or applying cosmetics or lip balm is prohibited at the scene of operations. Refer to SOP IC #6, Part II.

Used needles and other sharps shall be disposed of in approved sharps containers. Needles will not be recapped, resheathed, bent, broken, or separated from disposable syringes. **The most common occupational blood exposure occurs when needles are recapped.**

Sharps containers will be easily accessible on-scene

Disposable resuscitation equipment will be used whenever possible. For CPR, the order

of preference is:

1. Disposable bag-valve mask.
2. Bag-valve mask with disposable mask, and rest of unit can be disinfected.
3. Demand valve resuscitator with disposable mask.
4. Disposable pocket mask with one-way valve.
5. Mouth-to-mouth resuscitation.

Mouth-to-mouth resuscitation will be performed only as a last resort if no other equipment is available. All members, who are first responders, will be issued pocket masks with one-way valves to minimize the need for mouth-to-mouth resuscitation. Disposable resuscitation equipment will be kept readily available during on-scene operations.

Patients with suspected airborne communicable diseases will be transported with the patient wearing a face mask whenever possible. Ambulance windows will be open and ventilation systems turned on full whenever possible.

Personal protective equipment will be removed after leaving the work area, and as soon as possible if contaminated.

After use, all PPE will be disposed of at the clinic in appropriate containers marked for biohazard waste. If unable to dispose of PPE at clinic, all PPE will be placed in leak proof bags, color coded and marked as a biohazard, and transported back to the clinic for proper disposal.

The senior officer will handle on-scene public relations. The public should be reassured that infection control PPE is used as a matter of routine for the protection of all members and the victims that they treat. The use of PPE does not imply that a given victim may have a communicable disease.

No medical information will be released on scene. Media queries will be referred to the senior officer. Patient confidentiality will be maintained at all times.

At conclusion of on-scene operations, all potentially contaminated patient care equipment will be removed for appropriate disposal or decontamination and reuse.

SOP # 6: Post-Response (Housekeeping)

I. EQUIPMENT

A. Unit - Station cleaning and decontamination

1. All responders and appropriate support staff will be trained in decontamination procedures as outlined in this policy.
2. Appropriate cleaning products for decontamination are provided and should be used according to instructions in all cases.
3. Reserve equipment will be maintained to replace grossly contaminated equipment if needed.
4. Minor contamination can be cleaned and decontaminated in the field.
5. When gross contamination occurs, the senior on duty officer is to be notified by the crew.
6. The senior responder should determine the extent of the contamination and determine if the crew has been exposed. The following process should be implemented in collaboration with the Designated Officer.
 - a. If any crewmember has had an exposure, the Rescue Captain will be notified and appropriate medical treatment and evaluations will be done in accordance with the post exposure procedures outlined in the infection control section.
 - b. The unit must not be placed back in service until it has been decontaminated. If the unit can be safely decontaminated in the field, it need not be decontaminated at the station.
 - c. The crew will not be placed back in service with contaminated clothing or gear.

EQUIPMENT AND UNIT CLEANING AND DISINFECTION PROCEDURE:

Cleaning and disinfection guidelines vary depending on the medical condition of the patient transported, and the type of contamination, if any. Disinfection procedures are dictated by need. If the patient transported has no outward symptoms of infection (e.g., active coughing or sneezing) and is not a high risk of exposure (e.g., copious amounts of body fluids), disinfection procedures are minimal. If the patient exhibits any signs of being an exposure risk, the guidelines that follow should be used after transport is complete.

WEEKLY CLEANING

The ambulance should be cleaned and inspected weekly for visible signs of contamination. Minimally, this cleaning should include all patient contact areas, walls, ceilings, and floors. Use

any cleaner to remove dirt and gross contaminants; however, the final disinfection of the surfaces should be accomplished using only approved disinfectant.

REMEMBER: WASH FIRST, AND THEN DISINFECT!!!!

THOROUGH CLEANING

When transporting an infectious or high-risk patient, specific procedures should be followed to avoid cross-contamination:

Disposal: all disposable biohazardous waste must be properly disposed of in garbage bags provided and then at an appropriate biohazardous disposal receptacle at the clinic or the biohazardous trashcan at the station. Sharp items such as needles and vials must be disposed of using a puncture-proof container, and may not be placed in garbage bags.

GLOVES SHALL BE WORN WHENEVER HANDLING CONTAMINATED WASTE.

Disinfect by wiping: reusable equipment that will not have invasive or mucous membrane contact (e.g. backboard, stretchers) must be cleaned thoroughly, then wiped down with an approved disinfectant solution. If the equipment will come in contact with a patient's skin or mucous membranes, it must be rinsed thoroughly with clean water after disinfection. If the equipment has moving parts that become contaminated, procedures listed below for disinfecting by soaking should be used. If the moving parts involve biomedical equipment or objects that cannot be soaked, saturation of the area should be performed using the approved disinfectant.

Floor, wall, ceiling, squad bench, and other areas that become grossly soiled should be cleaned and disinfected following these same procedures.

Gloves must always be used when performing any disinfecting function, and proper precautions should be used as indicated by the chemical company's MSDS sheets or package labeling.

Disinfect by soaking: reusable equipment that has or may come in contact with mucous membranes or been used during invasive procedures must be disassembled, cleaned thoroughly, and then placed in an approved detergent disinfectant for the prescribed length of time recommended by the manufactures.

Bleach soak:

20 minutes if the item will not come in contact with the patient's mucous membranes

30 minutes if the item will come in contact with the patient's mucous membranes

ALWAYS RINSE THOROUGHLY AFTER DISINFECTING EQUIPEMENT

Gloves and masks must always be used when performing any disinfecting function using hazardous chemicals, and proper precautions should be used as indicated by the chemical warning labels and MSDS sheets.

Airborne Contamination: after removal of the patient, the ambulance should be aired for a minimum of 10 minutes to allow dispersal of the air-borne contaminant. After the unit has been aired, the procedures for disinfection by wiping should be followed for all exposed surfaces. Items contaminated with infective material (e.g. oxygen tubing, mask, etc.) must be treated as biohazard, following the cleaning or disposal procedures previously mentioned in this section.

UNIT CLEANING / DISINFECTION GUIDE

Type of isolation	walls washed	linens changed	Pt. Care supplies discarded/disinfected	cleaning supplies discarded/disinfected
Standard Precautions	X*	X	X	X
Respiratory Isolation	X	X	X	

X = Required

X* = Required if visibly soiled

UNIT CLEANING / DISINFECTION TABLE

<u>Article</u>	<u>Decontamination Procedure</u>
Airways	1
Backboard	2
Bite Blocks	1
BP cuffs: cloth	4
BP cuffs: tubes, gauge, bladder	2
Bulb Syringe	1
C-Collar	2
Dressings and paper products	1
Drug Boxes	2
Electronic Equip	2
Linens	4
Mast Suits	2
Monitors	2
Needles, syringes	1
Oxygen equip: flow meters	2
Oxygen equip: regulators	2
Oxygen equip: tanks	2
Oxygen equip: tubes, masks	1
Penlights	2
Pocket Masks	1 or 3
Restraint cotton	1
Restraint leather	1 or 2
Resuscitators, BVM	1 or 3
Scissors	3
Splints: metal	3
Splints: wood	1
Stethoscope	2
Straps: cloth	3
Straps: plastic	2
Stretch/mattress*	2
Suction unit/tubes	1

*Mattress cover wipe unless hole then replace

1- Dispose

Dispose of in bag, seal and then place in waste container at clinic or station. Sharp objects such as needles, stylets, and vials should be disposed of in puncture-proof containers.

2 - Clean and Disinfect by Wiping

Item must be cleaned and all debris removed. AFTER initial cleaning, wipe down with cloth soaked in an approved disinfectant. If object will come into contact with patient's skin or mucous membranes, rinse with clean water and allow to air dry, otherwise just air dry. Surface

areas of ambulance should be sprayed/wiped with approved disinfectant and allowed to air dry.

3 - Clean and Disinfect by Soaking

Item must be thoroughly cleaned with all debris removed, and soaked in detergent disinfectant. The product manufacturer's instructions for usage should be followed. After disinfection, items must be rinsed thoroughly.

4 - Linens**

Items such as linen that are contaminated will be placed in linen hampers at the clinic for cleaning and decontamination.

** Personal clothing, BP cuffs, etc. can be washed at clinic. See laundry guide

II. CONSUMING ITEMS IN PATIENT CARE AREAS

There will be no eating, drinking, smoking, applying cosmetics, applying lip balm, nor handling of contact lenses in any patient care area. Any infraction of this policy will be dealt with firmly.

It is necessary to isolate the driving compartment from the patient care compartment of the unit. It is imperative that the driving compartment be kept free of contamination from blood and body fluids. This will allow eating, drinking, applying cosmetics, applying lip balm, handling contact lenses, and like activities to be conducted in the cab.

BACKGROUND:

The cab (driving compartment) of our ambulance units is a separate work area from the patient compartment. Because of this distinction, we must have a separate procedure for appropriate activities in the driving compartment. This distinction is for the safety and welfare of our employees/volunteers, and is designed to prevent the driving compartment from being exposed to bloodborne pathogens.

PROCEDURE:

EMS requires all contaminated personal protective equipment to be removed and hands cleaned with appropriate hand sanitizer or antiseptic towelette prior to entry into the driving compartment of the unit.

In the unexpected event that it is suspected that the driving compartment may possibly have been exposed to bloodborne pathogens, it is imperative that no eating, drinking, applying cosmetics, application of lip balm, nor handling of contact lenses be done in that work area until it has been thoroughly disinfected.

All units will be supplied with appropriate sanitizer to thoroughly clean any small accidental contamination. Gross contamination may require a thorough cleaning and disinfection at the station.

It should be made clear that any breach of the above modified procedures may not only

jeopardize one's health but will also subject the person to disciplinary measures. As this is a change in industry practices, a change in training or behavior will need to occur. To drive this change we must ensure that absolutely no deviations from this policy be made. This will be strictly enforced.

III. LAUNDRY

The clinic maintains a washer and dryer in the utility room. This is primarily for laundry (sheets, towels, etc.). Occasionally personal clothing will become contaminated and need to be laundered. The laundry may be done in the clinic's machines using the following procedure.

PROCEDURE:

Laundry area must be clear of all other laundry.

Contaminated laundry shall be placed in the washing machine with laundry detergent and disinfectant. Hot water must be used to help destroy bacteria. Once the laundry has been done, a second cycle, with no laundry, should be run using a 10% bleach solution. All of this must be accomplished before other laundry can be put in the machine.

Signs will be placed on the washing machine when this process is being done.

SOP #IC 7: Post-Exposure Protocols

Any member exposed to potentially infectious material will immediately wash the exposed area with soap and water, or saline wash if the eyes are involved.

Any member having an occupational communicable disease exposure will immediately report the exposure to the Rescue Captain and Designated Officer. Needle stick injuries will be reported to the Rescue Captain immediately and as soon as possible to the Designated (Infection Control) Officer.

The member will fill out a communicable disease exposure report within twenty-four hours for any of the following exposures:

- Needle stick injury.
- Break in skin caused by a potentially contaminated object.
- Splash of blood or other potentially infectious material onto eyes, mucous membranes, or non-intact skin.
- Mouth-to-mouth resuscitation without pocket mask/one-way valve.
- Other exposure that the member may feel is significant.

The report will include details of the task being performed, the means of transmission, the portal of entry, and the type of PPE in use at the time.

The Rescue Captain will review the communicable disease exposure report and forward it to the Medical Director and Designated Officer.

The Designated Officer will evaluate the report for exposure hazards. If a possible exposure occurred, medical evaluation by the Medical Director or designee will be arranged by the Rescue Captain no later than 48 hours post-exposure. If no exposure took place, the Rescue Captain will counsel the member on exposure hazards. The Designated Officer will complete the communicable disease exposure report, indicating disposition of medical management, and file the report in the member personal health file.

The Designated Officer will perform or refer members for infection control retraining or for stress management counseling if indicated. Spousal counseling will be available.

The source patient will be traced to the receiving medical facility by the Rescue Captain. The Rescue Captain will notify the receiving facility that a communicable disease exposure took place, and request an infectious disease determination, as provided under the Ryan White Act of 1990. The receiving facility staff will make requests for consent to test the source patient for HIV and HBV. The source patient has the right to refuse such testing under present laws.

The Medical Director or designee will provide appropriate diagnostic workup and treatment of members with communicable disease exposures. Services may include long-

term follow-up and member or spousal counseling.

Under the Ryan White Act, medical treatment facilities will notify the Rescue Captain of any patient transported by members of the department with a diagnosis of an airborne transmissible disease. When so notified, the Rescue Captain will contact members involved and schedule medical evaluation with the Medical Director of the department.

Although not required by the Ryan White Act, medical treatment facilities may provide similar notification of diagnosis of blood borne or other potentially communicable disease if a member provided care or transportation to the source patient, and if disease transmission could have taken place. This policy will be carried out through cooperative agreements between medical treatment facilities and this department. Patient confidentiality will be preserved in any notification procedure.

SOP # IC 8: Compliance and Quality Monitoring/Program Evaluation

Compliance and quality monitoring

The Rescue Captain will collect compliance and quality monitoring data including:

- Inspections of station facilities

- Observation of on-scene activities

- Analysis of reported exposures to communicable diseases

A semi-annual quality and compliance report will be done.

Program evaluation

The Infection Control Program will be reevaluated at least annually by the EMS Manager to ensure that the program is both appropriate and effective.

In addition, the Infection Control Program will be reevaluated as needed to reflect any significant changes in assigned tasks or procedures; in medical knowledge related to infection control; or in regulatory matters.

The Medical Director will actively participate in program reevaluations to ensure that the program remains state of the art.